

REVIEW OF SYSTEMS – Answer all questions

URINARY

Frequent urination..... No Yes
 Burning or painful urination..... No Yes
 Blood in urine..... No Yes
 Incontinence or dribbling..... No Yes
 Sexual difficulty..... No Yes
 Male – testicle pain..... No Yes
 Male – does regular testicle exams..... No Yes
 Male – have you had a prostate exam.. No Yes
 Female – pain with periods..... No Yes
 Female – irregular periods..... No Yes
 Female – vaginal discharge..... No Yes
 Female – on birth control..... No Yes
 Female – vaginal infection in past..... No Yes
 Female – have you had abnormal PAP.. No Yes

SKIN

Rash or itching..... No Yes
 Do you do regular breast exams No Yes
 Breast pain..... No Yes
 Breast lump..... No Yes
 Breast discharge..... No Yes

CONSTITUTIONAL

Good general health lately..... No Yes
 Recent weight change..... No Yes
 Headaches..... No Yes

EYES

Wear glasses/contact lens..... No Yes

ENT

Sinus problems..... No Yes
 Sore throat or voice change..... No Yes
 Swollen glands in neck..... No Yes

CARDIOVASCULAR

Heart trouble..... No Yes
 Chest pains..... No Yes
 Sudden heart beat changes..... No Yes
 Swelling of feet, ankles or hands..... No Yes

RESPIRATORY

Frequent coughing..... No Yes
 Shortness of breath..... No Yes
 Asthma or wheezing..... No Yes

GASTROINTESTINAL

Loss of appetite..... No Yes
 Change in bowel movements..... No Yes
 Nausea or vomiting..... No Yes
 Frequent diarrhea..... No Yes
 Painful bowel movements/constipation.. No Yes
 Blood in stool..... No Yes
 Stomach pain..... No Yes

ENDOCRINE

Excessive thirst or urination..... No Yes
 Heat or cold intolerance..... No Yes
 Dry skin..... No Yes

MUSCULOSKELETAL

Joint pain..... No Yes
 Muscle pain or cramps..... No Yes
 Back pain..... No Yes

NEUROLOGICAL

Frequent or recurring headaches..... No Yes
 Light headed or dizzy..... No Yes
 Numbness or tingling sensations..... No Yes

PSYCHIATRIC

Nervousness..... No Yes
 Depression..... No Yes
 Sleep problems..... No Yes

HEMATOLOGIC/LYMPHATIC

Easily bruise or bleed..... No Yes
 Anemia..... No Yes
 Phlebitis..... No Yes
 Past transfusion..... No Yes

OTHER COMMENTS:

IMMUNIZATIONS	Yes	No	YEAR
Rubella	Yes	No	
Measles / Mumps	Yes	No	
Tetanus	Yes	No	
Polio	Yes	No	
Diphtheria	Yes	No	
Influenza	Yes	No	
Hemophilus Influenza	Yes	No	
Pneumonia	Yes	No	
Hepatitis	Yes	No	
Current Immunizations	Yes	No	

PREGNANCIES	ANSWERS
How many total children	
How many children born alive	
How many stillborn	
How many premature	
How many C-sections	
How many miscarriages	
How many abortions	

Patient's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____